

**House File 393 - Reprinted**

HOUSE FILE 393  
BY COMMITTEE ON HUMAN  
RESOURCES

(SUCCESSOR TO HSB 25)

(As Amended and Passed by the House March 13, 2017)

**A BILL FOR**

1 An Act relating to programs and activities under the purview  
2 of the department of public health, and including effective  
3 date provisions.

4 BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF IOWA:

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DIVISION I

PROGRAM FLEXIBILITY AND EFFICIENCIES

Section 1. Section 125.59, subsection 1, paragraph b, Code 2017, is amended to read as follows:

b. If the transferred amount for **this subsection** exceeds grant requests funded to the ten thousand dollar maximum, the Iowa department of public health may use the remainder for activities and public information resources that align with best practices for substance-related disorder prevention or to increase grants pursuant to **subsection 2**.

Sec. 2. Section 135.11, subsection 31, Code 2017, is amended by striking the subsection.

Sec. 3. Section 135.150, subsection 2, Code 2017, is amended to read as follows:

2. The department shall report ~~semiannually~~ annually to the general assembly's standing committees on government oversight regarding the operation of the gambling treatment program. The report shall include but is not limited to information on the moneys expended and grants awarded for operation of the gambling treatment program.

DIVISION II

MEDICAL HOME AND PATIENT-CENTERED HEALTH ADVISORY COUNCIL

Sec. 4. Section 135.15, Code 2017, is amended by adding the following new subsection:

NEW SUBSECTION. 6. For the purposes of this section, "*dental home*" means a network of individualized care based on risk assessment, which includes oral health education, dental screenings, preventive services, diagnostic services, treatment services, and emergency services.

Sec. 5. Section 135.159, Code 2017, is amended by striking the section and inserting in lieu thereof the following:

**135.159 Patient-centered health advisory council.**

1. The department shall establish a patient-centered health advisory council which shall include but is not limited to all of the following members, selected by their respective

1 organizations, and any other members the department determines  
2 necessary:

3 *a.* The director of human services, or the director's  
4 designee.

5 *b.* The commissioner of insurance, or the commissioner's  
6 designee.

7 *c.* A representative of the federation of Iowa insurers.

8 *d.* A representative of the Iowa dental association.

9 *e.* A representative of the Iowa nurses association.

10 *f.* A physician and an osteopathic physician licensed  
11 pursuant to chapter 148 who are family physicians and members  
12 of the Iowa academy of family physicians.

13 *g.* A health care consumer.

14 *h.* A representative of the Iowa collaborative safety net  
15 provider network established pursuant to section 135.153.

16 *i.* A representative of the Iowa developmental disabilities  
17 council.

18 *j.* A representative of the Iowa chapter of the American  
19 academy of pediatrics.

20 *k.* A representative of the child and family policy center.

21 *l.* A representative of the Iowa pharmacy association.

22 *m.* A representative of the Iowa chiropractic society.

23 *n.* A representative of the university of Iowa college of  
24 public health.

25 *o.* A certified palliative care physician.

26 2. The patient-centered health advisory council may utilize  
27 the assistance of other relevant public health and health care  
28 expertise when necessary to carry out the council's purposes  
29 and responsibilities.

30 3. A public member of the patient-centered health advisory  
31 council shall receive reimbursement for actual expenses  
32 incurred while serving in the member's official capacity  
33 only if the member is not eligible for reimbursement by the  
34 organization the member represents.

35 4. The purposes of the patient-centered health advisory

1 council shall include all of the following:

2     *a.* To serve as a resource on emerging health care  
3 transformation initiatives in Iowa.

4     *b.* To convene stakeholders in Iowa to streamline efforts  
5 that support state-level and community-level integration and  
6 focus on reducing fragmentation of the health care system.

7     *c.* To encourage partnerships and synergy between community  
8 health care partners in the state who are working on new  
9 system-level models to provide better health care at lower  
10 costs by focusing on shifting from volume-based to value-based  
11 health care.

12     *d.* To lead discussions on the transformation of the  
13 health care system to a patient-centered infrastructure that  
14 integrates and coordinates services and supports to address  
15 social determinants of health and to meet population health  
16 goals.

17     *e.* To provide a venue for education and information  
18 gathering for stakeholders and interested parties to learn  
19 about emerging health care initiatives across the state.

20     *f.* To develop recommendations for submission to the  
21 department related to health care transformation issues.

22     Sec. 6. Section 249N.2, subsections 15 and 19, Code 2017,  
23 are amended to read as follows:

24     15. "*Medical home*" means ~~medical home as defined in~~  
25 section 135.157, a team approach to providing health care that  
26 originates in a primary care setting; fosters a partnership  
27 among the patient, the personal provider, and other health care  
28 professionals, and where appropriate, the patient's family;  
29 utilizes the partnership to access and integrate all medical  
30 and nonmedical health-related services across all elements of  
31 the health care system and the patient's community as needed by  
32 the patient and the patient's family to achieve maximum health  
33 potential; maintains a centralized, comprehensive record of all  
34 health-related services to promote continuity of care; and has  
35 all of the following characteristics:

- 1 a. A personal provider.
- 2 b. A provider-directed team-based medical practice.
- 3 c. Whole person orientation.
- 4 d. Coordination and integration of care.
- 5 e. Quality and safety.
- 6 f. Enhanced access to health care.
- 7 g. A payment system that appropriately recognizes the added
- 8 value provided to patients who have a patient-centered medical
- 9 home.

10 19. *“Primary medical provider”* means the personal provider  
11 ~~as defined in [section 135.157](#)~~ trained to provide first contact  
12 and continuous and comprehensive care to a member, chosen by  
13 a member or to whom a member is assigned under the Iowa health  
14 and wellness plan.

15 Sec. 7. Section 249N.2, Code 2017, is amended by adding the  
16 following new subsections:

17 NEW SUBSECTION. 17A. *“Personal provider”* means the  
18 patient’s first point of contact in the health care system  
19 with a primary care provider who identifies the patient’s  
20 health-related needs and, working with a team of health  
21 care professionals and providers of medical and nonmedical  
22 health-related services, provides for and coordinates  
23 appropriate care to address the health-related needs  
24 identified.

25 NEW SUBSECTION. 18A. *“Primary care provider”* includes but  
26 is not limited to any of the following licensed or certified  
27 health care professionals who provide primary care:

- 28 a. A physician who is a family or general practitioner, a
- 29 pediatrician, an internist, an obstetrician, or a gynecologist.
- 30 b. An advanced registered nurse practitioner.
- 31 c. A physician assistant.
- 32 d. A chiropractor.

33 Sec. 8. Section 249N.6, subsection 2, paragraph c, Code  
34 2017, is amended to read as follows:

- 35 c. The department shall develop a mechanism for primary

1 medical providers, medical homes, and participating accountable  
2 care organizations to jointly facilitate member care  
3 coordination. The Iowa health and wellness plan shall provide  
4 for reimbursement of care coordination services provided  
5 under the plan ~~consistent with the reimbursement methodology~~  
6 ~~developed pursuant to [section 135.159](#).~~

7 Sec. 9. Section 249N.6, subsection 3, paragraph a, Code  
8 2017, is amended to read as follows:

9 a. The department shall provide procedures for accountable  
10 care organizations that emerge through local markets to  
11 participate in the Iowa health and wellness plan provider  
12 network. Such accountable care organizations shall incorporate  
13 the medical home ~~as defined and specified in chapter 135,~~  
14 ~~division XXII,~~ as a foundation and shall emphasize whole-person  
15 orientation and coordination and integration of both clinical  
16 services and nonclinical community and social supports that  
17 address social determinants of health. A participating  
18 accountable care organization shall enter into a contract with  
19 the department to ensure the coordination and management of the  
20 health of attributed members, to produce quality health care  
21 outcomes, and to control overall cost.

22 Sec. 10. PALLIATIVE CARE REVIEW — PATIENT-CENTERED HEALTH  
23 ADVISORY COUNCIL. The patient-centered health advisory council  
24 shall review the current level of public awareness regarding  
25 and the availability of palliative care services in the state  
26 and shall submit a report to the governor and the general  
27 assembly by December 31, 2017, including the council's findings  
28 and providing recommendations to increase public awareness  
29 and reduce barriers to access to palliative care services  
30 throughout the state.

31 Sec. 11. REPEAL. Sections 135.157 and 135.158, Code 2017,  
32 are repealed.

33 DIVISION III

34 WORKFORCE PROGRAMMING

35 Sec. 12. Section 84A.11, subsection 4, Code 2017, is amended

1 to read as follows:

2 4. The nursing workforce data clearinghouse shall be  
3 established and maintained in a manner consistent with the  
4 health care delivery infrastructure and health care workforce  
5 resources strategic plan developed pursuant to section ~~135.164~~  
6 135.163.

7 Sec. 13. Section 135.107, subsection 3, Code 2017, is  
8 amended to read as follows:

9 3. The center for rural health and primary care shall  
10 establish a primary care provider recruitment and retention  
11 endeavor, to be known as PRIMECARRE. The endeavor shall  
12 include a health care workforce and community support grant  
13 program, and a primary care provider loan repayment program,  
14 ~~and a primary care provider community scholarship program~~. The  
15 endeavor shall be developed and implemented in a manner to  
16 promote and accommodate local creativity in efforts to recruit  
17 and retain health care professionals to provide services in  
18 the locality. The focus of the endeavor shall be to promote  
19 and assist local efforts in developing health care provider  
20 recruitment and retention programs. The center for rural  
21 health and primary care may enter into an agreement with the  
22 college student aid commission for the administration of the  
23 center's grant and loan repayment programs.

24 *a. Community Health care workforce and community support*  
25 *grant program.*

26 (1) The center for rural health and primary care shall adopt  
27 rules establishing an flexible application process ~~processes~~  
28 based upon the department's strategic plan to be used by the  
29 center to establish a grant assistance program as provided  
30 in this paragraph "a", and establishing the criteria to be  
31 used in evaluating the applications. Selection criteria  
32 shall include a method for prioritizing grant applications  
33 based on illustrated efforts to meet the health care provider  
34 needs of the locality and surrounding area. Such assistance  
35 may be in the form of a forgivable loan, grant, or other

1 nonfinancial assistance as deemed appropriate by the center.  
2 An application submitted ~~shall~~ may contain a commitment of at  
3 ~~least a dollar-for-dollar match of~~ matching funds for the grant  
4 assistance. Application may be made for assistance by a single  
5 community or group of communities or in response to programs  
6 recommended in the strategic plan to address health workforce  
7 shortages.

8 (2) Grants awarded under the program shall be ~~subject to the~~  
9 ~~following limitations:~~

10 (a) ~~Ten thousand dollars for a single community or region~~  
11 ~~with a population of ten thousand or less. An award shall not~~  
12 ~~be made under this program to a community with a population of~~  
13 ~~more than ten thousand.~~

14 (b) ~~An amount not to exceed one dollar per capita for a~~  
15 ~~region in which the population exceeds ten thousand. For~~  
16 ~~purposes of determining the amount of a grant for a region,~~  
17 ~~the population of the region shall not include the population~~  
18 ~~of any community with a population of more than ten thousand~~  
19 ~~located in the region~~ awarded to rural, underserved areas or  
20 special populations as identified by the department's strategic  
21 plan or evidence-based documentation.

22 *b. Primary care provider loan repayment program.*

23 (1) A primary care provider loan repayment program is  
24 established to increase the number of health professionals  
25 practicing primary care in federally designated health  
26 professional shortage areas of the state. Under the program,  
27 loan repayment may be made to a recipient for educational  
28 expenses incurred while completing an accredited health  
29 education program directly related to obtaining credentials  
30 necessary to practice the recipient's health profession.

31 (2) The center for rural health and primary care shall adopt  
32 rules relating to the establishment and administration of the  
33 primary care provider loan repayment program. Rules adopted  
34 pursuant to this paragraph shall provide, at a minimum, for all  
35 of the following:

1 (a) Determination of eligibility requirements and  
2 qualifications of an applicant to receive loan repayment under  
3 the program, including but not limited to years of obligated  
4 service, clinical practice requirements, and residency  
5 requirements. One year of obligated service shall be provided  
6 by the applicant in exchange for each year of loan repayment,  
7 unless federal requirements otherwise require. Loan repayment  
8 under the program shall not be approved for a health provider  
9 whose license or certification is restricted by a medical  
10 regulatory authority of any jurisdiction of the United States,  
11 other nations, or territories.

12 (b) Identification of federally designated health  
13 professional shortage areas of the state and prioritization of  
14 such areas according to need.

15 (c) Determination of the amount and duration of the loan  
16 repayment an applicant may receive, giving consideration to the  
17 availability of funds under the program, and the applicant's  
18 outstanding educational loans and professional credentials.

19 (d) Determination of the conditions of loan repayment  
20 applicable to an applicant.

21 (e) Enforcement of the state's rights under a loan repayment  
22 program contract, including the commencement of any court  
23 action.

24 (f) Cancellation of a loan repayment program contract for  
25 reasonable cause unless federal requirements otherwise require.

26 (g) Participation in federal programs supporting repayment  
27 of loans of health care providers and acceptance of gifts,  
28 grants, and other aid or amounts from any person, association,  
29 foundation, trust, corporation, governmental agency, or other  
30 entity for the purposes of the program.

31 (h) Upon availability of state funds, determination of  
32 eligibility criteria and qualifications for participating  
33 communities and applicants not located in federally designated  
34 shortage areas.

35 (i) Other rules as necessary.

1     ~~(3) The center for rural health and primary care may enter~~  
2 ~~into an agreement under [chapter 28E](#) with the college student~~  
3 ~~aid commission for the administration of this program.~~

4     ~~*c. Primary care provider community scholarship program.*~~

5     ~~(1) A primary care provider community scholarship program~~  
6 ~~is established to recruit and to provide scholarships to train~~  
7 ~~primary health care practitioners in federally designated~~  
8 ~~health professional shortage areas of the state. Under~~  
9 ~~the program, scholarships may be awarded to a recipient for~~  
10 ~~educational expenses incurred while completing an accredited~~  
11 ~~health education program directly related to obtaining the~~  
12 ~~credentials necessary to practice the recipient's health~~  
13 ~~profession.~~

14     ~~(2) The department shall adopt rules relating to the~~  
15 ~~establishment and administration of the primary care provider~~  
16 ~~community scholarship program. Rules adopted pursuant to~~  
17 ~~this paragraph shall provide, at a minimum, for all of the~~  
18 ~~following:~~

19     ~~(a) Determination of eligibility requirements and~~  
20 ~~qualifications of an applicant to receive scholarships under~~  
21 ~~the program, including but not limited to years of obligated~~  
22 ~~service, clinical practice requirements, and residency~~  
23 ~~requirements. One year of obligated service shall be provided~~  
24 ~~by the applicant in exchange for each year of scholarship~~  
25 ~~receipt, unless federal requirements otherwise require.~~

26     ~~(b) Identification of federally designated health~~  
27 ~~professional shortage areas of the state and prioritization of~~  
28 ~~such areas according to need.~~

29     ~~(c) Determination of the amount of the scholarship an~~  
30 ~~applicant may receive.~~

31     ~~(d) Determination of the conditions of scholarship to be~~  
32 ~~awarded to an applicant.~~

33     ~~(e) Enforcement of the state's rights under a scholarship~~  
34 ~~contract, including the commencement of any court action.~~

35     ~~(f) Cancellation of a scholarship contract for reasonable~~

1 ~~cause.~~

2 ~~(g) Participation in federal programs supporting~~  
3 ~~scholarships for health care providers and acceptance of gifts,~~  
4 ~~grants, and other aid or amounts from any person, association,~~  
5 ~~foundation, trust, corporation, governmental agency, or other~~  
6 ~~entity for the purposes of the program.~~

7 ~~(h) Upon availability of state funds, determination of~~  
8 ~~eligibility criteria and qualifications for participating~~  
9 ~~communities and applicants not located in federally designated~~  
10 ~~shortage areas.~~

11 ~~(i) Other rules as necessary.~~

12 ~~(3) The center for rural health and primary care may enter~~  
13 ~~into an agreement under [chapter 28E](#) with the college student~~  
14 ~~aid commission for the administration of this program.~~

15 Sec. 14. Section 135.107, subsection 4, paragraphs a, b, and  
16 c, Code 2017, are amended to read as follows:

17 a. Eligibility under any of the programs established under  
18 the primary care provider recruitment and retention endeavor  
19 shall be based upon a community health services assessment  
20 completed under [subsection 2](#), paragraph "a". A community  
21 or region, as applicable, shall submit a letter of intent  
22 to conduct a community health services assessment and to  
23 apply for assistance under [this subsection](#). The letter shall  
24 be in a form and contain information as determined by the  
25 center. A letter of intent shall be submitted to the center by  
26 January 1 preceding the fiscal year for which an application  
27 for assistance is to be made. Participation in a community  
28 health services assessment process shall be documented by the  
29 community or region.

30 b. Assistance under [this subsection](#) shall not be granted  
31 until such time as the community or region making application  
32 has completed ~~the~~ a community health services assessment and  
33 adopted a long-term community health services assessment and  
34 developmental plan. In addition to any other requirements, a  
35 ~~developmental~~ an applicant's plan shall include, to the extent

1 possible, a clear commitment to informing high school students  
 2 of the health care opportunities which may be available to such  
 3 students.

4 c. The center for rural health and primary care shall  
 5 seek additional assistance and resources from other state  
 6 departments and agencies, federal agencies and grant programs,  
 7 private organizations, and any other person, as appropriate.  
 8 The center is authorized and directed to accept on behalf of  
 9 the state any grant or contribution, federal or otherwise,  
 10 made to assist in meeting the cost of carrying out the purpose  
 11 of this subsection. All federal grants to and the federal  
 12 receipts of the center are appropriated for the purpose set  
 13 forth in such federal grants or receipts. Funds appropriated  
 14 by the general assembly to the center for implementation of  
 15 this subsection shall first be used for securing any available  
 16 federal funds requiring a state match, with remaining funds  
 17 being used for the health care workforce and community support  
 18 grant program.

19 Sec. 15. Section 135.107, subsection 5, paragraph a, Code  
 20 2017, is amended to read as follows:

21 a. There is established an advisory committee to the  
 22 center for rural health and primary care consisting of one  
 23 representative, approved by the respective agency, of each  
 24 of the following agencies: the department of agriculture  
 25 and land stewardship, the ~~Iowa~~ department of public health,  
 26 the department of inspections and appeals, ~~the~~ a national or  
 27 regional institute for rural health policy, ~~the rural health~~  
 28 ~~resource center~~, the institute of agricultural medicine  
 29 and occupational health, and the Iowa state association of  
 30 counties. The governor shall appoint two representatives  
 31 of consumer groups active in rural health issues and a  
 32 representative of each of two farm organizations active within  
 33 the state, a representative of an agricultural business in  
 34 the state, a representative of a critical needs hospital,  
 35 a practicing rural family physician, a practicing rural

1 physician assistant, a practicing rural advanced registered  
2 nurse practitioner, and a rural health practitioner who is  
3 not a physician, physician assistant, or advanced registered  
4 nurse practitioner, as members of the advisory committee. The  
5 advisory committee shall also include as members two state  
6 representatives, one appointed by the speaker of the house of  
7 representatives and one by the minority leader of the house,  
8 and two state senators, one appointed by the majority leader of  
9 the senate and one by the minority leader of the senate.

10 Sec. 16. Section 135.163, Code 2017, is amended to read as  
11 follows:

12 **135.163 Health ~~and long-term~~ care access.**

13 The department shall coordinate public and private efforts  
14 to develop and maintain an appropriate health care delivery  
15 infrastructure and a stable, well-qualified, diverse, and  
16 sustainable health care workforce in this state. The health  
17 care delivery infrastructure and the health care workforce  
18 shall address the broad spectrum of health care needs of Iowans  
19 throughout their lifespan ~~including long-term care needs~~. The  
20 department shall, at a minimum, do all of the following:

21 1. Develop a strategic plan for health care delivery  
22 infrastructure and health care workforce resources in this  
23 state.

24 2. Provide for the continuous collection of data to provide  
25 a basis for health care strategic planning and health care  
26 policymaking.

27 3. Make recommendations regarding the health care delivery  
28 infrastructure and the health care workforce that assist  
29 in monitoring current needs, predicting future trends, and  
30 informing policymaking.

31 Sec. 17. Section 135.175, subsection 1, paragraph b, Code  
32 2017, is amended to read as follows:

33 *b.* A health care workforce shortage fund is created in  
34 the state treasury as a separate fund under the control of  
35 the department, in cooperation with the entities identified

1 in [this section](#) as having control over the accounts within  
 2 the fund. The fund and the accounts within the fund shall  
 3 be controlled and managed in a manner consistent with the  
 4 principles specified and the strategic plan developed pursuant  
 5 to ~~sections~~ section 135.163 and ~~135.164~~.

6 Sec. 18. Section 135.175, subsections 6 and 7, Code 2017,  
 7 are amended to read as follows:

8 6. *a.* Moneys in the fund and the accounts in the fund shall  
 9 only be appropriated in a manner consistent with the principles  
 10 specified and the strategic plan developed pursuant to ~~sections~~  
 11 section 135.163 and ~~135.164~~ to support the medical residency  
 12 training state matching grants program, the fulfilling Iowa's  
 13 need for dentists matching grant program, and to provide  
 14 funding for state health care workforce shortage programs as  
 15 provided in [this section](#).

16 *b.* State programs that may receive funding from the fund  
 17 and the accounts in the fund, if specifically designated for  
 18 the purpose of drawing down federal funding, are the primary  
 19 care recruitment and retention endeavor (PRIMECARRE), the Iowa  
 20 affiliate of the national rural recruitment and retention  
 21 network, the oral and health delivery systems bureau of the  
 22 department, the primary care office and shortage designation  
 23 program, and the state office of rural health, ~~and the Iowa~~  
 24 ~~health workforce center~~, administered through the oral and  
 25 health delivery systems bureau of ~~health care access~~ of the  
 26 department of public health; ~~the area health education centers~~  
 27 ~~programs at Des Moines university — osteopathic medical center~~  
 28 ~~and the university of Iowa; the Iowa collaborative safety net~~  
 29 ~~provider network established pursuant to [section 135.153](#)~~; any  
 30 entity identified by the federal government entity through  
 31 which federal funding for a specified health care workforce  
 32 shortage initiative is received; and a program developed in  
 33 accordance with the strategic plan developed by the department  
 34 of public health in accordance with ~~sections~~ section 135.163  
 35 and ~~135.164~~.

1 ~~c. State appropriations to the fund shall be allocated in~~  
2 ~~equal amounts to each of the accounts within the fund, unless~~  
3 ~~otherwise specified in the appropriation or allocation. Any~~  
4 federal funding received for the purposes of addressing state  
5 health care workforce shortages shall be deposited in the  
6 health care workforce shortage national initiatives account,  
7 unless otherwise specified by the source of the funds, and  
8 shall be used as required by the source of the funds. If use  
9 of the federal funding is not designated, the funds shall be  
10 used in accordance with the strategic plan developed by the  
11 department of public health in accordance with ~~sections~~ section  
12 135.163 and 135.164, or to address workforce shortages as  
13 otherwise designated by the department of public health. Other  
14 sources of funding shall be deposited in the fund or account  
15 and used as specified by the source of the funding.

16 7. No more than five percent of the moneys in any of the  
17 accounts within the fund, ~~not to exceed one hundred thousand~~  
18 ~~dollars in each account~~, shall be used for administrative  
19 purposes, unless otherwise provided by the appropriation,  
20 allocation, or source of the funds.

21 Sec. 19. REPEAL. Sections 135.164 and 135.180, Code 2017,  
22 are repealed.

23 DIVISION IV

24 UNFUNDED OR OUTDATED PROGRAM PROVISIONS

25 Sec. 20. Section 135.11, subsection 25, Code 2017, is  
26 amended by striking the subsection.

27 Sec. 21. Section 135.141, subsection 2, paragraph c, Code  
28 2017, is amended by striking the paragraph.

29 Sec. 22. Section 135.141, subsection 2, paragraph e, Code  
30 2017, is amended to read as follows:

31 e. For the purpose of ~~paragraphs "c" and~~ paragraph "d",  
32 an employee or agent of the department may enter into and  
33 examine any premises containing potentially dangerous agents  
34 with the consent of the owner or person in charge of the  
35 premises or, if the owner or person in charge of the premises

1 refuses admittance, with an administrative search warrant  
2 obtained under [section 808.14](#). Based on findings of the risk  
3 assessment and examination of the premises, the director may  
4 order reasonable safeguards or take any other action reasonably  
5 necessary to protect the public health pursuant to rules  
6 adopted to administer [this subsection](#).

7 Sec. 23. Section 901B.1, subsection 4, paragraph a, Code  
8 2017, is amended to read as follows:

9 a. The district department of correctional services shall  
10 place an individual committed to it under [section 907.3](#) to the  
11 sanction and level of supervision which is appropriate to the  
12 individual based upon a current risk assessment evaluation.  
13 Placements may be to levels two and three of the corrections  
14 continuum. ~~The district department may, with the approval of~~  
15 ~~the Iowa department of public health and the department of~~  
16 ~~corrections, place an individual in a level three substance~~  
17 ~~abuse treatment facility established pursuant to section~~  
18 ~~135.130, to assist the individual in complying with a condition~~  
19 ~~of probation.~~ The district department may, with the approval  
20 of the department of corrections, place an individual in a  
21 level four violator facility established pursuant to section  
22 904.207 only as a penalty for a violation of a condition  
23 imposed under [this section](#).

24 Sec. 24. REPEAL. Sections 135.26, 135.29, 135.130, and  
25 135.152, Code 2017, are repealed.

26 DIVISION V

27 MISCELLANEOUS PROVISIONS

28 Sec. 25. Section 135A.2, subsection 6, Code 2017, is amended  
29 to read as follows:

30 6. *"Local board of health"* means ~~a county or district board~~  
31 ~~of health~~ the same as defined in section 137.102.

32 Sec. 26. REPEAL. Section 135.132, Code 2017, is repealed.

33 DIVISION VI

34 IOWA HEALTH INFORMATION NETWORK

35 Sec. 27. Section 136.3, subsection 13, Code 2017, is amended

1 by striking the subsection.

2 Sec. 28. EFFECTIVE DATE. This division of this Act  
3 takes effect upon the assumption of the administration and  
4 governance, including but not limited to the assumption of the  
5 assets and liabilities, of the Iowa health information network  
6 by the designated entity as defined in 2015 Iowa Acts, ch.73,  
7 section 2. The department of public health shall notify the  
8 Code editor of the date of such assumption by the designated  
9 entity.

10 DIVISION VII

11 ORGANIZED DELIVERY SYSTEMS

12 Sec. 29. Section 135H.3, subsection 2, Code 2017, is amended  
13 to read as follows:

14 2. If a child is diagnosed with a biologically based mental  
15 illness as defined in [section 514C.22](#) and meets the medical  
16 assistance program criteria for admission to a psychiatric  
17 medical institution for children, the child shall be deemed  
18 to meet the acuity criteria for medically necessary inpatient  
19 benefits under a group policy, contract, or plan providing  
20 for third-party payment or prepayment of health, medical, and  
21 surgical coverage benefits issued by a carrier, as defined in  
22 [section 513B.2](#), ~~or by an organized delivery system authorized~~  
23 ~~under 1993 Iowa Acts, ch. 158~~, that is subject to section  
24 [514C.22](#). Such medically necessary benefits shall not be  
25 excluded or denied as care that is substantially custodial in  
26 nature under [section 514C.22, subsection 8](#), paragraph "b".

27 Sec. 30. Section 505.32, subsection 2, paragraph h, Code  
28 2017, is amended by striking the paragraph.

29 Sec. 31. Section 505.32, subsection 4, paragraph b,  
30 subparagraphs (1) and (2), Code 2017, are amended to read as  
31 follows:

32 (1) The commissioner may establish methodologies to provide  
33 uniform and consistent side-by-side comparisons of the health  
34 care coverage options that are offered by carriers, ~~organized~~  
35 ~~delivery systems~~, and public programs in this state including

1 but not limited to benefits covered and not covered, the amount  
2 of coverage for each service, including copays and deductibles,  
3 administrative costs, and any prior authorization requirements  
4 for coverage.

5 (2) The commissioner may require each carrier, ~~organized~~  
6 ~~delivery system~~, and public program in this state to describe  
7 each health care coverage option offered by that carrier,  
8 ~~organized delivery system~~, or public program in a manner  
9 so that the various options can be compared as provided in  
10 subparagraph (1).

11 Sec. 32. Section 507B.4, subsection 1, Code 2017, is amended  
12 to read as follows:

13 1. For purposes of **subsection 3**, paragraph "p", "insurer"  
14 means an entity providing a plan of health insurance, health  
15 care benefits, or health care services, or an entity subject  
16 to the jurisdiction of the commissioner performing utilization  
17 review, including an insurance company offering sickness and  
18 accident plans, a health maintenance organization, ~~an organized~~  
19 ~~delivery system authorized under 1993 Iowa Acts, ch. 158, and~~  
20 ~~licensed by the department of public health~~, a nonprofit health  
21 service corporation, a plan established pursuant to chapter  
22 509A for public employees, or any other entity providing a  
23 plan of health insurance, health care benefits, or health care  
24 services. However, "insurer" does not include an entity that  
25 sells disability income or long-term care insurance.

26 Sec. 33. Section 507B.4A, subsection 2, paragraph a, Code  
27 2017, is amended to read as follows:

28 a. An insurer providing accident and sickness insurance  
29 under **chapter 509, 514, or 514A**; a health maintenance  
30 organization; ~~an organized delivery system authorized under~~  
31 ~~1993 Iowa Acts, ch. 158, and licensed by the department of~~  
32 ~~public health~~; or another entity providing health insurance or  
33 health benefits subject to state insurance regulation shall  
34 either accept and pay or deny a clean claim.

35 Sec. 34. Section 509.3A, subsection 11, Code 2017, is

1 amended by striking the subsection.

2 Sec. 35. Section 509.19, subsection 2, paragraph d, Code  
3 2017, is amended by striking the paragraph.

4 Sec. 36. Section 509A.6, Code 2017, is amended to read as  
5 follows:

6 **509A.6 Contract with insurance carrier, or health maintenance**  
7 **organization, ~~or organized delivery system.~~**

8 The governing body may contract with a nonprofit corporation  
9 operating under the provisions of **this chapter** or chapter  
10 514 or with any insurance company having a certificate of  
11 authority to transact an insurance business in this state with  
12 respect of a group insurance plan, which may include life,  
13 accident, health, hospitalization and disability insurance  
14 during period of active service of such employees, with the  
15 right of any employee to continue such life insurance in force  
16 after termination of active service at such employee's sole  
17 expense; may contract with a nonprofit corporation operating  
18 under and governed by the provisions of **this chapter** or chapter  
19 514 with respect of any hospital or medical service plan; and  
20 may contract with a health maintenance organization ~~or an~~  
21 ~~organized delivery system~~ authorized to operate in this state  
22 with respect to health maintenance organization ~~or organized~~  
23 ~~delivery system~~ activities.

24 Sec. 37. Section 513B.2, subsection 8, paragraph k, Code  
25 2017, is amended by striking the paragraph.

26 Sec. 38. Section 513B.5, Code 2017, is amended to read as  
27 follows:

28 **513B.5 Provisions on renewability of coverage.**

29 1. Health insurance coverage subject to **this chapter** is  
30 renewable with respect to all eligible employees or their  
31 dependents, at the option of the small employer, except for one  
32 or more of the following reasons:

33 a. The health insurance coverage sponsor fails to pay, or to  
34 make timely payment of, premiums or contributions pursuant to  
35 the terms of the health insurance coverage.

1     *b.* The health insurance coverage sponsor performs an  
2 act or practice constituting fraud or makes an intentional  
3 misrepresentation of a material fact under the terms of the  
4 coverage.

5     *c.* Noncompliance with the carrier's ~~or organized delivery~~  
6 ~~system's~~ minimum participation requirements.

7     *d.* Noncompliance with the carrier's ~~or organized delivery~~  
8 ~~system's~~ employer contribution requirements.

9     *e.* A decision by the carrier ~~or organized delivery system~~  
10 to discontinue offering a particular type of health insurance  
11 coverage in the state's small employer market. Health  
12 insurance coverage may be discontinued by the carrier ~~or~~  
13 ~~organized delivery system~~ in that market only if the carrier ~~or~~  
14 ~~organized delivery system~~ does all of the following:

15     (1) Provides advance notice of its decision to discontinue  
16 such plan to the commissioner ~~or director of public health~~.  
17 Notice to the commissioner ~~or director~~, at a minimum, shall be  
18 no less than three days prior to the notice provided for in  
19 subparagraph (2) to affected small employers, participants, and  
20 beneficiaries.

21     (2) Provides notice of its decision not to renew such  
22 plan to all affected small employers, participants, and  
23 beneficiaries no less than ninety days prior to the nonrenewal  
24 of the plan.

25     (3) Offers to each plan sponsor of the discontinued  
26 coverage, the option to purchase any other coverage currently  
27 offered by the carrier ~~or organized delivery system~~ to other  
28 employers in this state.

29     (4) Acts uniformly, in opting to discontinue the coverage  
30 and in offering the option under subparagraph (3), without  
31 regard to the claims experience of the sponsors under the  
32 discontinued coverage or to a health status-related factor  
33 relating to any participants or beneficiaries covered or new  
34 participants or beneficiaries who may become eligible for the  
35 coverage.

1 *f.* A decision by the carrier ~~or organized delivery system~~ to  
2 discontinue offering and to cease to renew all of its health  
3 insurance coverage delivered or issued for delivery to small  
4 employers in this state. A carrier ~~or organized delivery~~  
5 ~~system~~ making such decision shall do all of the following:

6 (1) Provide advance notice of its decision to discontinue  
7 such coverage to the commissioner ~~or director of public health~~.  
8 Notice to the commissioner ~~or director~~, at a minimum, shall be  
9 no less than three days prior to the notice provided for in  
10 subparagraph (2) to affected small employers, participants, and  
11 beneficiaries.

12 (2) Provide notice of its decision not to renew such  
13 coverage to all affected small employers, participants, and  
14 beneficiaries no less than one hundred eighty days prior to the  
15 nonrenewal of the coverage.

16 (3) Discontinue all health insurance coverage issued or  
17 delivered for issuance to small employers in this state and  
18 cease renewal of such coverage.

19 *g.* The membership of an employer in an association, which  
20 is the basis for the coverage which is provided through such  
21 association, ceases, but only if the termination of coverage  
22 under this paragraph occurs uniformly without regard to  
23 any health status-related factor relating to any covered  
24 individual.

25 *h.* The commissioner ~~or director of public health~~ finds that  
26 the continuation of the coverage is not in the best interests  
27 of the policyholders or certificate holders, or would impair  
28 the carrier's ~~or organized delivery system's~~ ability to meet  
29 its contractual obligations.

30 *i.* At the time of coverage renewal, a carrier ~~or organized~~  
31 ~~delivery system~~ may modify the health insurance coverage for  
32 a product offered under group health insurance coverage in  
33 the small group market, for coverage that is available in  
34 such market other than only through one or more bona fide  
35 associations, if such modification is consistent with the laws

1 of this state, and is effective on a uniform basis among group  
2 health insurance coverage with that product.

3 2. A carrier ~~or organized delivery system~~ that elects not to  
4 renew health insurance coverage under [subsection 1](#), paragraph  
5 "f", shall not write any new business in the small employer  
6 market in this state for a period of five years after the date  
7 of notice to the commissioner ~~or director of public health~~.

8 3. [This section](#), with respect to a carrier ~~or organized~~  
9 ~~delivery system~~ doing business in one established geographic  
10 service area of the state, applies only to such carrier's ~~or~~  
11 ~~organized delivery system's~~ operations in that service area.

12 Sec. 39. Section 513B.6, unnumbered paragraph 1, Code 2017,  
13 is amended to read as follows:

14 A small employer carrier ~~or organized delivery system~~ shall  
15 make reasonable disclosure in solicitation and sales materials  
16 provided to small employers of all of the following:

17 Sec. 40. Section 513B.6, subsection 2, Code 2017, is amended  
18 to read as follows:

19 2. The provisions concerning the small employer carrier's  
20 ~~or organized delivery system's~~ right to change premium rates  
21 and factors, including case characteristics, which affect  
22 changes in premium rates.

23 Sec. 41. Section 513B.7, Code 2017, is amended to read as  
24 follows:

25 **513B.7 Maintenance of records.**

26 1. A small employer carrier ~~or organized delivery system~~  
27 shall maintain at its principal place of business a complete  
28 and detailed description of its rating practices and renewal  
29 underwriting practices, including information and documentation  
30 which demonstrate that its rating methods and practices are  
31 based upon commonly accepted actuarial assumptions and are in  
32 accordance with sound actuarial principles.

33 2. A small employer carrier ~~or organized delivery system~~  
34 shall file each March 1 with the commissioner ~~or the director~~  
35 ~~of public health~~ an actuarial certification that the small

1 employer carrier ~~or organized delivery system~~ is in compliance  
2 with [this section](#) and that the rating methods of the small  
3 employer carrier ~~or organized delivery system~~ are actuarially  
4 sound. A copy of the certification shall be retained by the  
5 small employer carrier ~~or organized delivery system~~ at its  
6 principal place of business.

7 3. A small employer carrier ~~or organized delivery system~~  
8 shall make the information and documentation described in  
9 subsection 1 available to the commissioner ~~or the director of~~  
10 ~~public health~~ upon request. The information is not a public  
11 record or otherwise subject to disclosure under [chapter 22](#),  
12 and is considered proprietary and trade secret information  
13 and is not subject to disclosure by the commissioner ~~or the~~  
14 ~~director of public health~~ to persons outside of the division ~~or~~  
15 ~~department~~ except as agreed to by the small employer carrier ~~or~~  
16 ~~organized delivery system~~ or as ordered by a court of competent  
17 jurisdiction.

18 Sec. 42. Section 513B.9A, subsection 1, unnumbered  
19 paragraph 1, Code 2017, is amended to read as follows:

20 A carrier ~~or organized delivery system~~ offering group health  
21 insurance coverage shall not establish rules for eligibility,  
22 including continued eligibility, of an individual to enroll  
23 under the terms of the coverage based on any of the following  
24 health status-related factors in relation to the individual or  
25 a dependent of the individual:

26 Sec. 43. Section 513B.9A, subsection 4, paragraph a, Code  
27 2017, is amended to read as follows:

28 a. A carrier ~~or organized delivery system~~ offering health  
29 insurance coverage shall not require an individual, as a  
30 condition of enrollment or continued enrollment under the  
31 coverage, to pay a premium or contribution which is greater  
32 than a premium or contribution for a similarly situated  
33 individual enrolled in the coverage on the basis of a health  
34 status-related factor in relation to the individual or to a  
35 dependent of an individual enrolled under the coverage.

1     Sec. 44. Section 513B.9A, subsection 4, paragraph b,  
2 subparagraph (2), Code 2017, is amended to read as follows:

3     (2) Prevent a carrier ~~or organized delivery system~~  
4 offering group health insurance coverage from establishing  
5 premium discounts or rebates or modifying otherwise applicable  
6 copayments or deductibles in return for adherence to programs  
7 of health promotion and disease prevention.

8     Sec. 45. Section 513B.10, Code 2017, is amended to read as  
9 follows:

10     **513B.10 Availability of coverage.**

11     1. *a.* A carrier ~~or an organized delivery system~~ that offers  
12 health insurance coverage in the small group market shall  
13 accept every small employer that applies for health insurance  
14 coverage and shall accept for enrollment under such coverage  
15 every eligible individual who applies for enrollment during the  
16 period in which the individual first becomes eligible to enroll  
17 under the terms of the health insurance coverage and shall not  
18 place any restriction which is inconsistent with eligibility  
19 rules established under [this chapter](#).

20     *b.* A carrier ~~or organized delivery system~~ that offers health  
21 insurance coverage in the small group market through a network  
22 plan may do either of the following:

23     (1) Limit employers that may apply for such coverage to  
24 those with eligible individuals who live, work, or reside in  
25 the service area for such network plan.

26     (2) Deny such coverage to such employers within the service  
27 area of such plan if the carrier ~~or organized delivery system~~  
28 has demonstrated to the applicable state authority both of the  
29 following:

30     (a) The carrier ~~or organized delivery system~~ will not have  
31 the capacity to deliver services adequately to enrollees of any  
32 additional groups because of its obligations to existing group  
33 contract holders and enrollees.

34     (b) The carrier ~~or organized delivery system~~ is applying  
35 this subparagraph uniformly to all employers without regard to

1 the claims experience of those employers and their employees  
2 and their dependents, or any health status-related factor  
3 relating to such employees or dependents.

4 *c.* A carrier ~~or organized delivery system~~, upon denying  
5 health insurance coverage in any service area pursuant to  
6 paragraph "b", subparagraph (2), shall not offer coverage in the  
7 small group market within such service area for a period of one  
8 hundred eighty days after the date such coverage is denied.

9 *d.* A carrier ~~or organized delivery system~~ may deny health  
10 insurance coverage in the small group market if the issuer has  
11 demonstrated to the commissioner ~~or director of public health~~  
12 both of the following:

13 (1) The carrier ~~or organized delivery system~~ does not have  
14 the financial reserves necessary to underwrite additional  
15 coverage.

16 (2) The carrier ~~or organized delivery system~~ is applying the  
17 provisions of this paragraph uniformly to all employers in the  
18 small group market in this state consistent with state law and  
19 without regard to the claims experience of those employers and  
20 the employees and dependents of such employers, or any health  
21 status-related factor relating to such employees and their  
22 dependents.

23 *e.* A carrier ~~or organized delivery system~~, upon denying  
24 health insurance coverage pursuant to paragraph "d", shall not  
25 offer coverage in connection with health insurance coverages  
26 in the small group market in this state for a period of one  
27 hundred eighty days after the date such coverage is denied or  
28 until the carrier ~~or organized delivery system~~ has demonstrated  
29 to the commissioner ~~or director of public health~~ that the  
30 carrier ~~or organized delivery system~~ has sufficient financial  
31 reserves to underwrite additional coverage, whichever is later.  
32 The commissioner ~~or director~~ may provide for the application of  
33 this paragraph on a service area-specific basis.

34 *f.* Paragraph "a" shall not be construed to preclude  
35 a carrier ~~or organized delivery system~~ from establishing

1 employer contribution rules or group participation rules for  
2 the offering of health insurance coverage in the small group  
3 market.

4 2. A carrier ~~or organized delivery system~~, subject to  
5 subsection 1, shall issue health insurance coverage to an  
6 eligible small employer that applies for the coverage and  
7 agrees to make the required premium payments and satisfy the  
8 other reasonable provisions of the health insurance coverage  
9 not inconsistent with [this chapter](#). A carrier ~~or organized~~  
10 ~~delivery system~~ is not required to issue health insurance  
11 coverage to a self-employed individual who is covered by, or is  
12 eligible for coverage under, health insurance coverage offered  
13 by an employer.

14 3. Health insurance coverage for small employers shall  
15 satisfy all of the following:

16 a. A carrier ~~or organized delivery system~~ offering group  
17 health insurance coverage, with respect to a participant or  
18 beneficiary, may impose a preexisting condition exclusion only  
19 as follows:

20 (1) The exclusion relates to a condition, whether physical  
21 or mental, regardless of the cause of the condition, for  
22 which medical advice, diagnosis, care, or treatment was  
23 recommended or received within the six-month period ending on  
24 the enrollment date. However, genetic information shall not be  
25 treated as a condition under this subparagraph in the absence  
26 of a diagnosis of the condition related to such information.

27 (2) The exclusion extends for a period of not more than  
28 twelve months, or eighteen months in the case of a late  
29 enrollee, after the enrollment date.

30 (3) The period of any such preexisting condition exclusion  
31 is reduced by the aggregate of the periods of creditable  
32 coverage applicable to the participant or beneficiary as of the  
33 enrollment date.

34 b. A carrier ~~or organized delivery system~~ offering group  
35 health insurance coverage shall not impose any preexisting

1 condition exclusion as follows:

2 (1) In the case of a child who is adopted or placed for  
3 adoption before attaining eighteen years of age and who, as of  
4 the last day of the thirty-day period beginning on the date  
5 of the adoption or placement for adoption, is covered under  
6 creditable coverage. This subparagraph shall not apply to  
7 coverage before the date of such adoption or placement for  
8 adoption.

9 (2) In the case of an individual who, as of the last day  
10 of the thirty-day period beginning with the date of birth, is  
11 covered under creditable coverage.

12 (3) Relating to pregnancy as a preexisting condition.

13 ~~c. A carrier or organized delivery system~~ shall waive  
14 any waiting period applicable to a preexisting condition  
15 exclusion or limitation period with respect to particular  
16 services under health insurance coverage for the period  
17 of time an individual was covered by creditable coverage,  
18 provided that the creditable coverage was continuous to a  
19 date not more than sixty-three days prior to the effective  
20 date of the new coverage. Any period that an individual  
21 is in a waiting period for any coverage under group health  
22 insurance coverage, or is in an affiliation period, shall not  
23 be taken into account in determining the period of continuous  
24 coverage. A health maintenance organization that does not  
25 use preexisting condition limitations in any of its health  
26 insurance coverage may impose an affiliation period. For  
27 purposes of [this section](#), "*affiliation period*" means a period  
28 of time not to exceed sixty days for new entrants and not to  
29 exceed ninety days for late enrollees during which no premium  
30 shall be collected and coverage issued is not effective, so  
31 long as the affiliation period is applied uniformly, without  
32 regard to any health status-related factors. This paragraph  
33 does not preclude application of a waiting period applicable  
34 to all new enrollees under the health insurance coverage,  
35 provided that any ~~carrier or organized delivery system~~ imposed

1 carrier-imposed waiting period is no longer than sixty days and  
2 is used in lieu of a preexisting condition exclusion.

3 *d.* Health insurance coverage may exclude coverage for late  
4 enrollees for preexisting conditions for a period not to exceed  
5 eighteen months.

6 *e.* (1) Requirements used by a carrier ~~or organized delivery~~  
7 ~~system~~ in determining whether to provide coverage to a small  
8 employer shall be applied uniformly among all small employers  
9 applying for coverage or receiving coverage from the carrier  
10 ~~or organized delivery system~~.

11 (2) In applying minimum participation requirements with  
12 respect to a small employer, a carrier ~~or organized delivery~~  
13 ~~system~~ shall not consider employees or dependents who have  
14 other creditable coverage in determining whether the applicable  
15 percentage of participation is met.

16 (3) A carrier ~~or organized delivery system~~ shall not  
17 increase any requirement for minimum employee participation  
18 or modify any requirement for minimum employer contribution  
19 applicable to a small employer at any time after the small  
20 employer has been accepted for coverage.

21 *f.* (1) If a carrier ~~or organized delivery system~~ offers  
22 coverage to a small employer, the carrier ~~or organized delivery~~  
23 ~~system~~ shall offer coverage to all eligible employees of the  
24 small employer and the employees' dependents. A carrier ~~or~~  
25 ~~organized delivery system~~ shall not offer coverage to only  
26 certain individuals or dependents in a small employer group or  
27 to only part of the group.

28 (2) Except as provided under paragraphs "a" and "d", a  
29 carrier ~~or organized delivery system~~ shall not modify health  
30 insurance coverage with respect to a small employer or any  
31 eligible employee or dependent through riders, endorsements, or  
32 other means, to restrict or exclude coverage or benefits for  
33 certain diseases, medical conditions, or services otherwise  
34 covered by the health insurance coverage.

35 *g.* A carrier ~~or organized delivery system~~ offering coverage

1 through a network plan shall not be required to offer coverage  
2 or accept applications pursuant to [subsection 1](#) with respect to  
3 a small employer where any of the following ~~apply~~ applies:

4 (1) The small employer does not have eligible individuals  
5 who live, work, or reside in the service area for the network  
6 plan.

7 (2) The small employer does have eligible individuals who  
8 live, work, or reside in the service area for the network plan,  
9 but the carrier ~~or organized delivery system~~, if required, has  
10 demonstrated to the commissioner ~~or the director of public~~  
11 ~~health~~ that it will not have the capacity to deliver services  
12 adequately to enrollees of any additional groups because of its  
13 obligations to existing group contract holders and enrollees  
14 and that it is applying the requirements of this lettered  
15 paragraph uniformly to all employers without regard to the  
16 claims experience of those employers and their employees and  
17 the employees' dependents, or any health status-related factor  
18 relating to such employees and dependents.

19 (3) A carrier ~~or organized delivery system~~, upon denying  
20 health insurance coverage in a service area pursuant to  
21 subparagraph (2), shall not offer coverage in the small  
22 employer market within such service area for a period of one  
23 hundred eighty days after the coverage is denied.

24 4. A carrier ~~or organized delivery system~~ shall not be  
25 required to offer coverage to small employers pursuant to  
26 subsection 1 for any period of time where the commissioner ~~or~~  
27 ~~director of public health~~ determines that the acceptance of the  
28 offers by small employers in accordance with [subsection 1](#) would  
29 place the carrier ~~or organized delivery system~~ in a financially  
30 impaired condition.

31 5. A carrier ~~or organized delivery system~~ shall not be  
32 required to provide coverage to small employers pursuant to  
33 subsection 1 if the carrier ~~or organized delivery system~~ elects  
34 not to offer new coverage to small employers in this state.  
35 However, a carrier ~~or organized delivery system~~ that elects not

1 to offer new coverage to small employers under **this subsection**  
2 shall be allowed to maintain its existing policies in the  
3 state, subject to the requirements of **section 513B.5**.

4 6. A carrier ~~or organized delivery system~~ that elects not to  
5 offer new coverage to small employers pursuant to **subsection 5**  
6 shall provide notice to the commissioner ~~or director of public~~  
7 ~~health~~ and is prohibited from writing new business in the small  
8 employer market in this state for a period of five years from  
9 the date of notice to the commissioner ~~or director~~.

10 Sec. 46. Section 513C.3, subsection 5, Code 2017, is amended  
11 to read as follows:

12 5. "*Carrier*" means any entity that provides individual  
13 health benefit plans in this state. For purposes of this  
14 chapter, carrier includes an insurance company, a group  
15 hospital or medical service corporation, a fraternal benefit  
16 society, a health maintenance organization, and any other  
17 entity providing an individual plan of health insurance  
18 or health benefits subject to state insurance regulation.  
19 ~~"Carrier" does not include an organized delivery system.~~

20 Sec. 47. Section 513C.3, subsection 7, Code 2017, is amended  
21 by striking the subsection.

22 Sec. 48. Section 513C.3, subsection 9, Code 2017, is amended  
23 to read as follows:

24 9. "*Established service area*" means a geographic area,  
25 as approved by the commissioner and based upon the carrier's  
26 certificate of authority to transact business in this state,  
27 within which the carrier is authorized to provide coverage ~~or~~  
28 ~~a geographic area, as approved by the director and based upon~~  
29 ~~the organized delivery system's license to transact business~~  
30 ~~in this state, within which the organized delivery system is~~  
31 ~~authorized to provide coverage.~~

32 Sec. 49. Section 513C.3, subsection 12, Code 2017, is  
33 amended by striking the subsection.

34 Sec. 50. Section 513C.3, subsection 15, paragraph a,  
35 subparagraph (3), Code 2017, is amended by striking the

1 subparagraph.

2 Sec. 51. Section 513C.3, subsection 18, Code 2017, is  
3 amended to read as follows:

4 18. *“Restricted network provision”* means a provision of an  
5 individual health benefit plan that conditions the payment  
6 of benefits, in whole or in part, on the use of health care  
7 providers that have entered into a contractual arrangement with  
8 the carrier ~~or the organized delivery system~~ to provide health  
9 care services to covered individuals.

10 Sec. 52. Section 513C.5, subsection 1, unnumbered paragraph  
11 1, Code 2017, is amended to read as follows:

12 Premium rates for any block of individual health benefit  
13 plan business issued on or after January 1, 1996, or the date  
14 rules are adopted by the commissioner of insurance ~~and the~~  
15 ~~director of public health~~ and become effective, whichever  
16 date is later, by a carrier subject to **this chapter** shall be  
17 limited to the composite effect of allocating costs among the  
18 following:

19 Sec. 53. Section 513C.6, Code 2017, is amended to read as  
20 follows:

21 **513C.6 Provisions on renewability of coverage.**

22 1. An individual health benefit plan subject to this  
23 chapter is renewable with respect to an eligible individual or  
24 dependents, at the option of the individual, except for one or  
25 more of the following reasons:

26 *a.* The individual fails to pay, or to make timely payment  
27 of, premiums or contributions pursuant to the terms of the  
28 individual health benefit plan.

29 *b.* The individual performs an act or practice constituting  
30 fraud or makes an intentional misrepresentation of a material  
31 fact under the terms of the individual health benefit plan.

32 *c.* A decision by the individual carrier ~~or organized~~  
33 ~~delivery system~~ to discontinue offering a particular type  
34 of individual health benefit plan in the state’s individual  
35 insurance market. An individual health benefit plan may be

1 discontinued by the carrier ~~or organized delivery system~~ in  
2 that market with the approval of the commissioner ~~or the~~  
3 ~~director~~ and only if the carrier ~~or organized delivery system~~  
4 does all of the following:

5 (1) Provides advance notice of its decision to discontinue  
6 such plan to the commissioner ~~or director~~. Notice to the  
7 commissioner ~~or director~~, at a minimum, shall be no less than  
8 three days prior to the notice provided for in subparagraph (2)  
9 to affected individuals.

10 (2) Provides notice of its decision not to renew such plan  
11 to all affected individuals no less than ninety days prior  
12 to the nonrenewal date of any discontinued individual health  
13 benefit plans.

14 (3) Offers to each individual of the discontinued plan the  
15 option to purchase any other health plan currently offered by  
16 the carrier ~~or organized delivery system~~ to individuals in this  
17 state.

18 (4) Acts uniformly in opting to discontinue the plan and  
19 in offering the option under subparagraph (3), without regard  
20 to the claims experience of any affected eligible individual  
21 or beneficiary under the discontinued plan or to a health  
22 status-related factor relating to any covered individuals or  
23 beneficiaries who may become eligible for the coverage.

24 *d.* A decision by the carrier ~~or organized delivery system~~  
25 to discontinue offering and to cease to renew all of its  
26 individual health benefit plans delivered or issued for  
27 delivery to individuals in this state. A carrier ~~or organized~~  
28 ~~delivery system~~ making such decision shall do all of the  
29 following:

30 (1) Provide advance notice of its decision to discontinue  
31 such plan to the commissioner ~~or director~~. Notice to the  
32 commissioner ~~or director~~, at a minimum, shall be no less than  
33 three days prior to the notice provided for in subparagraph (2)  
34 to affected individuals.

35 (2) Provide notice of its decision not to renew such plan

1 to all individuals and to the commissioner ~~or director~~ in each  
2 state in which an individual under the discontinued plan is  
3 known to reside, no less than one hundred eighty days prior to  
4 the nonrenewal of the plan.

5 e. The commissioner ~~or director~~ finds that the continuation  
6 of the coverage is not in the best interests of the  
7 individuals, or would impair the carrier's ~~or organized~~  
8 ~~delivery system's~~ ability to meet its contractual obligations.

9 2. At the time of coverage renewal, a carrier ~~or organized~~  
10 ~~delivery system~~ may modify the health insurance coverage for  
11 a policy form offered to individuals in the individual market  
12 so long as such modification is consistent with state law and  
13 effective on a uniform basis among all individuals with that  
14 policy form.

15 3. An individual carrier ~~or organized delivery system~~ that  
16 elects not to renew an individual health benefit plan under  
17 subsection 1, paragraph "d", shall not write any new business in  
18 the individual market in this state for a period of five years  
19 after the date of notice to the commissioner ~~or director~~.

20 4. [This section](#), with respect to a carrier ~~or organized~~  
21 ~~delivery system~~ doing business in one established geographic  
22 service area of the state, applies only to such carrier's ~~or~~  
23 ~~organized delivery system's~~ operations in that service area.

24 5. A carrier ~~or organized delivery system~~ offering coverage  
25 through a network plan is not required to renew or continue in  
26 force coverage or to accept applications from an individual who  
27 no longer resides or lives in, or is no longer employed in,  
28 the service area of such carrier ~~or organized delivery system~~,  
29 or no longer resides or lives in, or is no longer employed  
30 in, a service area for which the carrier is authorized to do  
31 business, but only if coverage is not offered or terminated  
32 uniformly without regard to health status-related factors of a  
33 covered individual.

34 6. A carrier ~~or organized delivery system~~ offering coverage  
35 through a bona fide association is not required to renew or

1 continue in force coverage or to accept applications from an  
2 individual through an association if the membership of the  
3 individual in the association on which the basis of coverage  
4 is provided ceases, but only if the coverage is not offered or  
5 terminated under this paragraph uniformly without regard to  
6 health status-related factors of a covered individual.

7 7. An individual who has coverage as a dependent under a  
8 basic or standard health benefit plan may, when that individual  
9 is no longer a dependent under such coverage, elect to continue  
10 coverage under the basic or standard health benefit plan if  
11 the individual so elects immediately upon termination of the  
12 coverage under which the individual was covered as a dependent.

13 Sec. 54. Section 513C.7, subsection 1, Code 2017, is amended  
14 to read as follows:

15 1. *a.* ~~(1)~~ A carrier shall file with the commissioner, in  
16 a form and manner prescribed by the commissioner, the basic  
17 or standard health benefit plan. A basic or standard health  
18 benefit plan filed pursuant to this paragraph may be used by  
19 a carrier beginning thirty days after it is filed unless the  
20 commissioner disapproves of its use.

21 ~~(2)~~ *b.* The commissioner may at any time, after providing  
22 notice and an opportunity for a hearing to the carrier,  
23 disapprove the continued use by a carrier of a basic or  
24 standard health benefit plan on the grounds that the plan does  
25 not meet the requirements of [this chapter](#).

26 ~~*b.* (1) An organized delivery system shall file with the~~  
27 ~~director, in a form and manner prescribed by the director,~~  
28 ~~the basic or standard health benefit plan to be used by the~~  
29 ~~organized delivery system. A basic or standard health benefit~~  
30 ~~plan filed pursuant to this paragraph may be used by the~~  
31 ~~organized delivery system beginning thirty days after it is~~  
32 ~~filed unless the director disapproves of its use.~~

33 ~~(2) The director may at any time, after providing notice and~~  
34 ~~an opportunity for a hearing to the organized delivery system,~~  
35 ~~disapprove the continued use by an organized delivery system of~~

1 ~~a basic or standard health benefit plan on the grounds that the~~  
2 ~~plan does not meet the requirements of [this chapter](#).~~

3 Sec. 55. Section 513C.7, subsection 3, Code 2017, is amended  
4 to read as follows:

5 3. A carrier ~~or an organized delivery system~~ shall not  
6 modify a basic or standard health benefit plan with respect  
7 to an individual or dependent through riders, endorsements,  
8 or other means to restrict or exclude coverage for certain  
9 diseases or medical conditions otherwise covered by the health  
10 benefit plan.

11 Sec. 56. Section 513C.9, subsections 1, 2, 3, 6, and 8, Code  
12 2017, are amended to read as follows:

13 1. A carrier, ~~an organized delivery system,~~ or an agent  
14 shall not do either of the following:

15 a. Encourage or direct individuals to refrain from  
16 filing an application for coverage with the carrier ~~or the~~  
17 ~~organized delivery system~~ because of the health status, claims  
18 experience, industry, occupation, or geographic location of the  
19 individuals.

20 b. Encourage or direct individuals to seek coverage from  
21 another carrier ~~or another organized delivery system~~ because of  
22 the health status, claims experience, industry, occupation, or  
23 geographic location of the individuals.

24 2. [Subsection 1](#), paragraph "a", shall not apply with respect  
25 to information provided by a carrier ~~or an organized delivery~~  
26 ~~system~~ or an agent to an individual regarding the established  
27 geographic service area of the carrier ~~or the organized~~  
28 ~~delivery system,~~ or the restricted network provision of the  
29 carrier ~~or the organized delivery system~~.

30 3. A carrier ~~or an organized delivery system~~ shall not,  
31 directly or indirectly, enter into any contract, agreement, or  
32 arrangement with an agent that provides for, or results in, the  
33 compensation paid to an agent for a sale of a basic or standard  
34 health benefit plan to vary because of the health status or  
35 permitted rating characteristics of the individual or the

1 individual's dependents.

2 6. Denial by a carrier ~~or an organized delivery system~~ of an  
3 application for coverage from an individual shall be in writing  
4 and shall state the reason or reasons for the denial.

5 8. If a carrier ~~or an organized delivery system~~ enters into  
6 a contract, agreement, or other arrangement with a third-party  
7 administrator to provide administrative, marketing, or other  
8 services related to the offering of individual health benefit  
9 plans in this state, the third-party administrator is subject  
10 to [this section](#) as if it were a carrier ~~or an organized~~  
11 ~~delivery system~~.

12 Sec. 57. Section 513C.10, subsection 1, paragraph a, Code  
13 2017, is amended to read as follows:

14 a. All persons that provide health benefit plans in this  
15 state including insurers providing accident and sickness  
16 insurance under [chapter 509](#), [514](#), or [514A](#), whether on an  
17 individual or group basis; fraternal benefit societies  
18 providing hospital, medical, or nursing benefits under chapter  
19 512B; and health maintenance organizations, ~~organized delivery~~  
20 ~~systems~~, other entities providing health insurance or health  
21 benefits subject to state insurance regulation, and all other  
22 insurers as designated by the board of directors of the Iowa  
23 comprehensive health insurance association with the approval of  
24 the commissioner shall be members of the association.

25 Sec. 58. Section 513C.10, subsection 2, paragraph a, Code  
26 2017, is amended to read as follows:

27 a. Rates for basic and standard coverages as provided in  
28 this chapter shall be determined by each carrier ~~or organized~~  
29 ~~delivery system~~ as the product of a basic and standard factor  
30 and the lowest rate available for issuance by that carrier ~~or~~  
31 ~~organized delivery system~~ adjusted for rating characteristics  
32 and benefits. Basic and standard factors shall be established  
33 annually by the Iowa comprehensive health insurance association  
34 board with the approval of the commissioner. Multiple basic  
35 and standard factors for a distinct grouping of basic and

1 standard policies may be established. A basic and standard  
 2 factor is limited to a minimum value defined as the ratio  
 3 of the average of the lowest rate available for issuance and  
 4 the maximum rate allowable by law divided by the lowest rate  
 5 available for issuance. A basic and standard factor is limited  
 6 to a maximum value defined as the ratio of the maximum rate  
 7 allowable by law divided by the lowest rate available for  
 8 issuance. The maximum rate allowable by law and the lowest  
 9 rate available for issuance is determined based on the rate  
 10 restrictions under [this chapter](#). For policies written after  
 11 January 1, 2002, rates for the basic and standard coverages  
 12 as provided in [this chapter](#) shall be calculated using the  
 13 basic and standard factors and shall be no lower than the  
 14 maximum rate allowable by law. However, to maintain assessable  
 15 loss assessments at or below one percent of total health  
 16 insurance premiums or payments as determined in accordance  
 17 with [subsection 6](#), the Iowa comprehensive health insurance  
 18 association board with the approval of the commissioner may  
 19 increase the value for any basic and standard factor greater  
 20 than the maximum value.

21 Sec. 59. Section 513C.10, subsections 3, 4, 7, 8, 9, and 10,  
 22 Code 2017, are amended to read as follows:

23 3. Following the close of each calendar year, the  
 24 association, in conjunction with the commissioner, shall  
 25 require each carrier ~~or organized delivery system~~ to report  
 26 the amount of earned premiums and the associated paid losses  
 27 for all basic and standard plans issued by the carrier ~~or~~  
 28 ~~organized delivery system~~. The reporting of these amounts must  
 29 be certified by an officer of the carrier ~~or organized delivery~~  
 30 ~~system~~.

31 4. The board shall develop procedures and assessment  
 32 mechanisms and make assessments and distributions as required  
 33 to equalize the individual carrier ~~and organized delivery~~  
 34 ~~system~~ gains or losses so that each carrier ~~or organized~~  
 35 ~~delivery system~~ receives the same ratio of paid claims to

1 ninety percent of earned premiums as the aggregate of all  
2 basic and standard plans insured by all carriers ~~and organized~~  
3 ~~delivery systems~~ in the state.

4 7. The board shall develop procedures for distributing  
5 the assessable loss assessments to each carrier ~~and organized~~  
6 ~~delivery system~~ in proportion to the carrier's ~~and organized~~  
7 ~~delivery system's~~ respective share of premium for basic and  
8 standard plans to the statewide total premium for all basic and  
9 standard plans.

10 8. The board shall ensure that procedures for collecting  
11 and distributing assessments are as efficient as possible  
12 for carriers ~~and organized delivery systems~~. The board may  
13 establish procedures which combine, or offset, the assessment  
14 from, and the distribution due to, a carrier ~~or organized~~  
15 ~~delivery system~~.

16 9. A carrier ~~or an organized delivery system~~ may  
17 petition the association board to seek remedy from writing a  
18 significantly disproportionate share of basic and standard  
19 policies in relation to total premiums written in this state  
20 for health benefit plans. Upon a finding that a carrier ~~or~~  
21 ~~organized delivery system~~ has written a disproportionate share,  
22 the board may agree to compensate the carrier ~~or organized~~  
23 ~~delivery system~~ either by paying to the carrier ~~or organized~~  
24 ~~delivery system~~ an additional fee not to exceed two percent  
25 of earned premiums from basic and standard policies for that  
26 carrier ~~or organized delivery system~~ or by petitioning the  
27 commissioner ~~or director, as appropriate,~~ for remedy.

28 10. ~~a.~~ The commissioner, upon a finding that the acceptance  
29 of the offer of basic and standard coverage by individuals  
30 pursuant to [this chapter](#) would place the carrier in a  
31 financially impaired condition, shall not require the carrier  
32 to offer coverage or accept applications for any period of time  
33 the financial impairment is deemed to exist.

34 ~~b.~~ ~~The director, upon a finding that the acceptance of the~~  
35 ~~offer of basic and standard coverage by individuals pursuant~~

1 to ~~this chapter~~ would place the organized delivery system in a  
2 financially impaired condition, shall not require the organized  
3 delivery system to offer coverage or accept applications for  
4 any period of time the financial impairment is deemed to exist.

5 Sec. 60. Section 514A.3B, subsection 3, paragraph k, Code  
6 2017, is amended by striking the paragraph.

7 Sec. 61. Section 514B.25A, Code 2017, is amended to read as  
8 follows:

9 **514B.25A Insolvency protection — assessment.**

10 1. Upon a health maintenance organization ~~or organized~~  
11 ~~delivery system~~ authorized to do business in this state and  
12 ~~licensed by the director of public health~~ being declared  
13 insolvent by the district court, the commissioner may levy an  
14 assessment on each health maintenance organization ~~or organized~~  
15 ~~delivery system~~ doing business in this state and ~~licensed by~~  
16 ~~the director of public health, as applicable,~~ to pay claims  
17 for uncovered expenditures for enrollees. The commissioner  
18 shall not assess an amount in any one calendar year which is  
19 more than two percent of the aggregate premium written by each  
20 health maintenance organization ~~or organized delivery system~~.

21 2. The commissioner may use funds obtained through an  
22 assessment under [subsection 1](#) to pay claims for uncovered  
23 expenditures for enrollees of an insolvent health maintenance  
24 organization ~~or organized delivery system~~ and administrative  
25 costs. The commissioner, by rule, may prescribe the time,  
26 manner, and form for filing claims under [this section](#). The  
27 commissioner may require claims to be allowed by an ancillary  
28 receiver or the domestic receiver or liquidator.

29 3. *a.* A receiver or liquidator of an insolvent health  
30 maintenance organization ~~or organized delivery system~~ shall  
31 allow a claim in the proceeding in an amount equal to uncovered  
32 expenditures and administrative costs paid under [this section](#).

33 *b.* A person receiving benefits under [this section](#) for  
34 uncovered expenditures is deemed to have assigned the rights  
35 under the covered health care plan certificates to the

1 commissioner to the extent of the benefits received. The  
2 commissioner may require an assignment of such rights by a  
3 payee, enrollee, or beneficiary, to the commissioner as a  
4 condition precedent to the receipt of such benefits. The  
5 commissioner is subrogated to these rights against the assets  
6 of the insolvent health maintenance organization ~~or organized~~  
7 ~~delivery system~~ that are held by a receiver or liquidator of  
8 a foreign jurisdiction.

9 c. The assigned subrogation rights of the commissioner and  
10 allowed claims under **this subsection** have the same priority  
11 against the assets of the insolvent health maintenance  
12 organization ~~or organized delivery system~~ as those claims of  
13 persons entitled to receive benefits under **this section** or for  
14 similar expenses in the receivership or liquidation.

15 4. If funds assessed under **subsection 1** are unused  
16 following the completion of the liquidation of an insolvent  
17 health maintenance organization ~~or organized delivery system~~,  
18 the commissioner shall distribute the remaining amounts, if  
19 such amounts are not de minimis, to the health maintenance  
20 organizations ~~or organized delivery systems~~ that were assessed.

21 5. The aggregate coverage of uncovered expenditures under  
22 this section shall not exceed three hundred thousand dollars  
23 with respect to one individual. Continuation of coverage  
24 shall cease after the lesser of one year after the health  
25 maintenance organization ~~or organized delivery system~~ is  
26 terminated by insolvency or the remaining term of the contract.  
27 The commissioner may provide continuation of coverage on a  
28 reasonable basis, including, but not limited to, continuation  
29 of the health maintenance organization ~~or organized delivery~~  
30 ~~system~~ contract or substitution of indemnity coverage in a form  
31 as determined by the commissioner.

32 6. The commissioner may waive an assessment of a health  
33 maintenance organization ~~or organized delivery system~~ if such  
34 organization ~~or system~~ is impaired financially or would be  
35 impaired financially as a result of such assessment. A health

1 maintenance organization ~~or organized delivery system~~ that  
2 fails to pay an assessment within thirty days after notice of  
3 the assessment is subject to a civil forfeiture of not more  
4 than one thousand dollars for each day the failure continues,  
5 and suspension or revocation of its certificate of authority.  
6 An action taken by the commissioner to enforce an assessment  
7 under [this section](#) may be appealed by the health maintenance  
8 organization ~~or organized delivery system~~ pursuant to chapter  
9 17A.

10 Sec. 62. Section 514C.10, subsection 2, paragraph e, Code  
11 2017, is amended by striking the paragraph.

12 Sec. 63. Section 514C.11, Code 2017, is amended to read as  
13 follows:

14 **514C.11 Services provided by licensed physician assistants  
15 and licensed advanced registered nurse practitioners.**

16 1. Notwithstanding [section 514C.6](#), a policy or contract  
17 providing for third-party payment or prepayment of health or  
18 medical expenses shall include a provision for the payment of  
19 necessary medical or surgical care and treatment provided by  
20 a physician assistant licensed pursuant to [chapter 148C](#), or  
21 provided by an advanced registered nurse practitioner licensed  
22 pursuant to [chapter 152](#) and performed within the scope of the  
23 license of the licensed physician assistant or the licensed  
24 advanced registered nurse practitioner if the policy or  
25 contract would pay for the care and treatment if the care and  
26 treatment were provided by a person engaged in the practice  
27 of medicine and surgery or osteopathic medicine and surgery  
28 under [chapter 148](#). The policy or contract shall provide that  
29 policyholders and subscribers under the policy or contract may  
30 reject the coverage for services which may be provided by a  
31 licensed physician assistant or licensed advanced registered  
32 nurse practitioner if the coverage is rejected for all  
33 providers of similar services. A policy or contract subject  
34 to [this section](#) shall not impose a practice or supervision  
35 restriction which is inconsistent with or more restrictive than

1 the restriction already imposed by law.

2 2. This section applies to services provided under a policy  
3 or contract delivered, issued for delivery, continued, or  
4 renewed in this state on or after July 1, 1996, and to an  
5 existing policy or contract, on the policy's or contract's  
6 anniversary or renewal date, or upon the expiration of the  
7 applicable collective bargaining contract, if any, whichever  
8 is later. This section does not apply to policyholders or  
9 subscribers eligible for coverage under Tit. XVIII of the  
10 federal Social Security Act or any similar coverage under a  
11 state or federal government plan.

12 3. For the purposes of this section, third-party payment or  
13 prepayment includes an individual or group policy of accident  
14 or health insurance or individual or group hospital or health  
15 care service contract issued pursuant to chapter 509, 514, or  
16 514A, an individual or group health maintenance organization  
17 contract issued and regulated under chapter 514B, ~~an organized~~  
18 ~~delivery system contract regulated under rules adopted by the~~  
19 ~~director of public health,~~ or a preferred provider organization  
20 contract regulated pursuant to chapter 514F.

21 4. Nothing in this section shall be interpreted to require  
22 an individual or group health maintenance organization, ~~an~~  
23 ~~organized delivery system,~~ or a preferred provider organization  
24 or arrangement to provide payment or prepayment for services  
25 provided by a licensed physician assistant or licensed advanced  
26 registered nurse practitioner unless the physician assistant's  
27 supervising physician, the physician-physician assistant team,  
28 the advanced registered nurse practitioner, or the advanced  
29 registered nurse practitioner's collaborating physician has  
30 entered into a contract or other agreement to provide services  
31 with the individual or group health maintenance organization, ~~the~~  
32 ~~organized delivery system,~~ or the preferred provider  
33 organization or arrangement.

34 Sec. 64. Section 514C.13, subsection 1, paragraph h, Code  
35 2017, is amended by striking the paragraph.

1     Sec. 65. Section 514C.13, subsection 2, Code 2017, is  
2 amended to read as follows:

3     2. A carrier ~~or organized delivery system~~ which offers to  
4 a small employer a limited provider network plan to provide  
5 health care services or benefits to the small employer's  
6 employees shall also offer to the small employer a point of  
7 service option to the limited provider network plan.

8     Sec. 66. Section 514C.13, subsection 3, unnumbered  
9 paragraph 1, Code 2017, is amended to read as follows:

10     A carrier ~~or organized delivery system~~ which offers to a  
11 large employer a limited provider network plan to provide  
12 health care services or benefits to the large employer's  
13 employees shall also offer to the large employer one or more  
14 of the following:

15     Sec. 67. Section 514C.14, subsections 1 and 3, Code 2017,  
16 are amended to read as follows:

17     1. Except as provided under [subsection 2 or 3](#), a carrier,  
18 as defined in [section 513B.2](#), ~~an organized delivery system~~  
19 ~~authorized under 1993 Iowa Acts, ch. 158~~, or a plan established  
20 pursuant to [chapter 509A](#) for public employees, which terminates  
21 its contract with a participating health care provider,  
22 shall continue to provide coverage under the contract to a  
23 covered person in the second or third trimester of pregnancy  
24 for continued care from such health care provider. Such  
25 persons may continue to receive such treatment or care through  
26 postpartum care related to the child birth and delivery.  
27 Payment for covered benefits and benefit levels shall be  
28 according to the terms and conditions of the contract.

29     3. A carrier, ~~organized delivery system~~, or a plan  
30 established under [chapter 509A](#), which terminates the contract  
31 of a participating health care provider for cause shall not  
32 be liable to pay for health care services provided by the  
33 health care provider to a covered person following the date of  
34 termination.

35     Sec. 68. Section 514C.15, Code 2017, is amended to read as

1 follows:

2 **514C.15 Treatment options.**

3 A carrier, as defined in [section 513B.2](#), ~~an organized~~  
4 ~~delivery system authorized under 1993 Iowa Acts, ch. 158,~~  
5 ~~and licensed by the director of public health,~~ or a plan  
6 established pursuant to [chapter 509A](#) for public employees,  
7 shall not prohibit a participating provider from, or penalize a  
8 participating provider for, doing either of the following:

9 1. Discussing treatment options with a covered individual,  
10 notwithstanding the carrier's, ~~organized delivery system's,~~ or  
11 plan's position on such treatment option.

12 2. Advocating on behalf of a covered individual within  
13 a review or grievance process established by the carrier,  
14 ~~organized delivery system,~~ or [chapter 509A](#) plan, or established  
15 by a person contracting with the carrier, ~~organized delivery~~  
16 ~~system,~~ or [chapter 509A](#) plan.

17 Sec. 69. Section 514C.16, subsection 1, Code 2017, is  
18 amended to read as follows:

19 1. A carrier, as defined in [section 513B.2](#), ~~an organized~~  
20 ~~delivery system authorized under 1993 Iowa Acts, ch. 158,~~  
21 ~~and licensed by the director of public health,~~ or a plan  
22 established pursuant to [chapter 509A](#) for public employees,  
23 which provides coverage for emergency services, is responsible  
24 for charges for emergency services provided to a covered  
25 individual, including services furnished outside any  
26 contractual provider network or preferred provider network.  
27 Coverage for emergency services is subject to the terms and  
28 conditions of the health benefit plan or contract.

29 Sec. 70. Section 514C.17, subsections 1 and 3, Code 2017,  
30 are amended to read as follows:

31 1. Except as provided under [subsection 2 or 3](#), if a carrier,  
32 as defined in [section 513B.2](#), ~~an organized delivery system~~  
33 ~~authorized under 1993 Iowa Acts, ch. 158,~~ or a plan established  
34 pursuant to [chapter 509A](#) for public employees, terminates its  
35 contract with a participating health care provider, a covered

1 individual who is undergoing a specified course of treatment  
 2 for a terminal illness or a related condition, with the  
 3 recommendation of the covered individual's treating physician  
 4 licensed under [chapter 148](#) may continue to receive coverage for  
 5 treatment received from the covered individual's physician for  
 6 the terminal illness or a related condition, for a period of  
 7 up to ninety days. Payment for covered benefits and benefit  
 8 levels shall be according to the terms and conditions of the  
 9 contract.

10 3. Notwithstanding [subsections 1 and 2](#), a carrier,  
 11 ~~organized delivery system~~, or a plan established under chapter  
 12 509A which terminates the contract of a participating health  
 13 care provider for cause shall not be required to cover health  
 14 care services provided by the health care provider to a covered  
 15 person following the date of termination.

16 Sec. 71. Section 514C.18, subsection 2, paragraph a,  
 17 subparagraph (6), Code 2017, is amended by striking the  
 18 subparagraph.

19 Sec. 72. Section 514C.19, subsection 7, paragraph a,  
 20 subparagraph (6), Code 2017, is amended by striking the  
 21 subparagraph.

22 Sec. 73. Section 514C.20, subsection 3, paragraph f, Code  
 23 2017, is amended by striking the paragraph.

24 Sec. 74. Section 514C.21, subsection 2, paragraph d, Code  
 25 2017, is amended by striking the paragraph.

26 Sec. 75. Section 514C.22, subsection 1, unnumbered  
 27 paragraph 1, Code 2017, is amended to read as follows:

28 Notwithstanding the uniformity of treatment requirements of  
 29 section 514C.6, a group policy, contract, or plan providing  
 30 for third-party payment or prepayment of health, medical, and  
 31 surgical coverage benefits issued by a carrier, as defined in  
 32 section 513B.2, ~~or by an organized delivery system authorized~~  
 33 ~~under 1993 Iowa Acts, ch. 158~~, shall provide coverage benefits  
 34 for treatment of a biologically based mental illness if either  
 35 of the following is satisfied:

1     Sec. 76. Section 514C.22, subsection 6, Code 2017, is  
2 amended to read as follows:

3     6. A carrier, ~~organized delivery system~~, or plan  
4 established pursuant to [chapter 509A](#) may manage the benefits  
5 provided through common methods including, but not limited to,  
6 providing payment of benefits or providing care and treatment  
7 under a capitated payment system, prospective reimbursement  
8 rate system, utilization control system, incentive system for  
9 the use of least restrictive and least costly levels of care,  
10 a preferred provider contract limiting choice of specific  
11 providers, or any other system, method, or organization  
12 designed to assure services are medically necessary and  
13 clinically appropriate.

14     Sec. 77. Section 514C.25, subsection 2, paragraph a,  
15 subparagraph (5), Code 2017, is amended by striking the  
16 subparagraph.

17     Sec. 78. Section 514C.26, subsection 5, paragraph a,  
18 subparagraph (6), Code 2017, is amended by striking the  
19 subparagraph.

20     Sec. 79. Section 514C.27, subsection 1, unnumbered  
21 paragraph 1, Code 2017, is amended to read as follows:

22     Notwithstanding the uniformity of treatment requirements  
23 of [section 514C.6](#), a group policy or contract providing for  
24 third-party payment or prepayment of health or medical expenses  
25 issued by a carrier, as defined in [section 513B.2](#), ~~or by an~~  
26 ~~organized delivery system authorized under 1993 Iowa Acts, ch.~~  
27 ~~158~~, shall provide coverage benefits to an insured who is a  
28 veteran for treatment of mental illness and substance abuse if  
29 either of the following is satisfied:

30     Sec. 80. Section 514C.27, subsection 6, Code 2017, is  
31 amended to read as follows:

32     6. A carrier, ~~organized delivery system~~, or plan  
33 established pursuant to [chapter 509A](#) may manage the benefits  
34 provided through common methods including but not limited to  
35 providing payment of benefits or providing care and treatment

1 under a capitated payment system, prospective reimbursement  
2 rate system, utilization control system, incentive system for  
3 the use of least restrictive and least costly levels of care,  
4 a preferred provider contract limiting choice of specific  
5 providers, or any other system, method, or organization  
6 designed to assure services are medically necessary and  
7 clinically appropriate.

8 Sec. 81. Section 514C.29, subsection 2, paragraph e, Code  
9 2017, is amended by striking the paragraph.

10 Sec. 82. Section 514C.30, subsection 2, paragraph e, Code  
11 2017, is amended by striking the paragraph.

12 Sec. 83. Section 514E.1, subsection 6, paragraph k, Code  
13 2017, is amended by striking the paragraph.

14 Sec. 84. Section 514E.1, subsection 17, Code 2017, is  
15 amended by striking the subsection.

16 Sec. 85. Section 514E.2, subsection 1, paragraph a, Code  
17 2017, is amended to read as follows:

18 ~~a. All carriers and all organized delivery systems licensed~~  
19 ~~by the director of public health providing health insurance or~~  
20 health care services in Iowa, whether on an individual or group  
21 basis, and all other insurers designated by the association's  
22 board of directors and approved by the commissioner shall be  
23 members of the association.

24 Sec. 86. Section 514E.2, subsection 2, paragraph a,  
25 subparagraph (3), Code 2017, is amended to read as follows:

26 (3) Two members selected by the members of the association,  
27 one of whom shall be a representative from a corporation  
28 operating pursuant to [chapter 514](#) on July 1, 1989, or  
29 any successor in interest, and one of whom shall be a  
30 representative of ~~an organized delivery system or an insurer~~  
31 providing coverage pursuant to [chapter 509](#) or [514A](#).

32 Sec. 87. Section 514E.7, subsection 1, paragraph a,  
33 subparagraphs (1) and (2), Code 2017, are amended to read as  
34 follows:

35 (1) A notice of rejection or refusal to issue substantially

1 similar insurance for health reasons by one carrier or  
2 ~~organized delivery system~~.

3 (2) A refusal by a carrier or ~~organized delivery system~~ to  
4 issue insurance except at a rate exceeding the plan rate.

5 Sec. 88. Section 514E.7, subsection 1, paragraph b, Code  
6 2017, is amended to read as follows:

7 b. A rejection or refusal by a carrier or ~~organized delivery~~  
8 ~~system~~ offering only stoploss, excess of loss, or reinsurance  
9 coverage with respect to an applicant under paragraph "a",  
10 subparagraphs (1) and (2), is not sufficient evidence for  
11 purposes of **this subsection**.

12 Sec. 89. Section 514E.9, Code 2017, is amended to read as  
13 follows:

14 **514E.9 Rules.**

15 Pursuant to **chapter 17A**, the commissioner ~~and the director~~  
16 ~~of public health~~ shall adopt rules to provide for disclosure  
17 by carriers ~~and organized delivery systems~~ of the availability  
18 of insurance coverage from the association, and to otherwise  
19 implement **this chapter**.

20 Sec. 90. Section 514E.11, Code 2017, is amended to read as  
21 follows:

22 **514E.11 Notice of association policy.**

23 Every carrier, including a health maintenance organization  
24 subject to **chapter 514B** ~~and an organized delivery system~~,  
25 authorized to provide health care insurance or coverage for  
26 health care services in Iowa, shall provide a notice of the  
27 availability of coverage by the association to any person  
28 who receives a rejection of coverage for health insurance  
29 or health care services, or a rate for health insurance or  
30 coverage for health care services that will exceed the rate of  
31 an association policy, and that person is eligible to apply  
32 for health insurance provided by the association. Application  
33 for the health insurance shall be on forms prescribed by the  
34 association's board of directors and made available to the  
35 carriers ~~and organized delivery systems~~ and other entities

1 providing health care insurance or coverage for health care  
2 services regulated by the commissioner.

3 Sec. 91. Section 514F.5, Code 2017, is amended to read as  
4 follows:

5 **514F.5 Experimental treatment review.**

6 1. A carrier, as defined in [section 513B.2](#), ~~an organized~~  
7 ~~delivery system authorized under 1993 Iowa Acts, ch. 158,~~ or a  
8 plan established pursuant to [chapter 509A](#) for public employees,  
9 that limits coverage for experimental medical treatment, drugs,  
10 or devices, shall develop and implement a procedure to evaluate  
11 experimental medical treatments and shall submit a description  
12 of the procedure to the division of insurance. The procedure  
13 shall be in writing and must describe the process used to  
14 determine whether the carrier, ~~organized delivery system,~~  
15 or [chapter 509A](#) plan will provide coverage for new medical  
16 technologies and new uses of existing technologies. The  
17 procedure, at a minimum, shall require a review of information  
18 from appropriate government regulatory agencies and published  
19 scientific literature concerning new medical technologies, new  
20 uses of existing technologies, and the use of external experts  
21 in making decisions. A carrier, ~~organized delivery system,~~  
22 or [chapter 509A](#) plan shall include appropriately licensed  
23 or qualified professionals in the evaluation process. The  
24 procedure shall provide a process for a person covered under  
25 a plan or contract to request a review of a denial of coverage  
26 because the proposed treatment is experimental. A review of  
27 a particular treatment need not be reviewed more than once a  
28 year.

29 2. A carrier, ~~organized delivery system,~~ or [chapter 509A](#)  
30 plan that limits coverage for experimental treatment, drugs, or  
31 devices shall clearly disclose such limitations in a contract,  
32 policy, or certificate of coverage.

33 Sec. 92. Section 514I.2, subsection 10, Code 2017, is  
34 amended to read as follows:

35 10. *"Participating insurer"* means any entity licensed by the

1 division of insurance of the department of commerce to provide  
2 health insurance in Iowa ~~or an organized delivery system~~  
3 ~~licensed by the director of public health~~ that has contracted  
4 with the department to provide health insurance coverage to  
5 eligible children under [this chapter](#).

6 Sec. 93. Section 514J.102, subsection 24, Code 2017, is  
7 amended to read as follows:

8 24. *"Health carrier"* means an entity subject to the  
9 insurance laws and regulations of this state, or subject  
10 to the jurisdiction of the commissioner, including an  
11 insurance company offering sickness and accident plans, a  
12 health maintenance organization, a nonprofit health service  
13 corporation, a plan established pursuant to [chapter 509A](#)  
14 for public employees, or any other entity providing a plan  
15 of health insurance, health care benefits, or health care  
16 services. ~~"Health carrier" includes, for purposes of this~~  
17 ~~chapter, an organized delivery system.~~

18 Sec. 94. Section 514J.102, subsection 29, Code 2017, is  
19 amended by striking the subsection.

20 Sec. 95. Section 514K.1, subsection 1, unnumbered paragraph  
21 1, Code 2017, is amended to read as follows:

22 A health maintenance organization, ~~an organized delivery~~  
23 ~~system~~, or an insurer using a preferred provider arrangement  
24 shall provide to each of its enrollees at the time of  
25 enrollment, and shall make available to each prospective  
26 enrollee upon request, written information as required by rules  
27 adopted by the commissioner ~~and the director of public health~~.  
28 The information required by rule shall include, but not be  
29 limited to, all of the following:

30 Sec. 96. Section 514K.1, subsection 2, Code 2017, is amended  
31 to read as follows:

32 2. The commissioner ~~and the director~~ shall annually publish  
33 a consumer guide providing a comparison by plan on performance  
34 measures, network composition, and other key information to  
35 enable consumers to better understand plan differences.

1     Sec. 97. Section 514L.1, subsection 3, Code 2017, is amended  
2 to read as follows:

3     3. *“Provider of third-party payment or prepayment of*  
4 *prescription drug expenses”* or *“provider”* means a provider of an  
5 individual or group policy of accident or health insurance or  
6 an individual or group hospital or health care service contract  
7 issued pursuant to [chapter 509](#), [514](#), or [514A](#), a provider of a  
8 plan established pursuant to [chapter 509A](#) for public employees,  
9 a provider of an individual or group health maintenance  
10 organization contract issued and regulated under [chapter 514B](#),  
11 ~~a provider of an organized delivery system contract regulated~~  
12 ~~under rules adopted by the director of public health~~, a  
13 provider of a preferred provider contract issued pursuant to  
14 [chapter 514F](#), a provider of a self-insured multiple employer  
15 welfare arrangement, and any other entity providing health  
16 insurance or health benefits which provide for payment or  
17 prepayment of prescription drug expenses coverage subject to  
18 state insurance regulation.

19     Sec. 98. Section 514L.2, subsection 1, paragraph a,  
20 unnumbered paragraph 1, Code 2017, is amended to read as  
21 follows:

22     A provider of third-party payment or prepayment of  
23 prescription drug expenses, including the provider’s agents or  
24 contractors and pharmacy benefits managers, that issues a card  
25 or other technology for claims processing and an administrator  
26 of the payor, excluding administrators of self-funded employer  
27 sponsored health benefit plans qualified under the federal  
28 Employee Retirement Income Security Act of 1974, shall issue  
29 to its insureds a card or other technology containing uniform  
30 prescription drug information. The commissioner of insurance  
31 shall adopt rules for the uniform prescription drug information  
32 card or technology applicable to those entities subject to  
33 regulation by the commissioner of insurance. ~~The director of~~  
34 ~~public health shall adopt rules for the uniform prescription~~  
35 ~~drug information card or technology applicable to organized~~

1 ~~delivery systems.~~ The rules shall require at least both of the  
2 following regarding the card or technology:

3 Sec. 99. Section 521F.2, subsection 7, Code 2017, is amended  
4 to read as follows:

5 7. "*Health organization*" means a health maintenance  
6 organization, limited service organization, dental or vision  
7 plan, hospital, medical and dental indemnity or service  
8 corporation or other managed care organization licensed under  
9 chapter 514, or 514B, ~~or 1993 Iowa Acts, ch. 158~~, or any other  
10 entity engaged in the business of insurance, risk transfer,  
11 or risk retention, that is subject to the jurisdiction of the  
12 commissioner of insurance ~~or the director of public health~~.  
13 "*Health organization*" does not include an insurance company  
14 licensed to transact the business of insurance under chapter  
15 508, 515, or 520, and which is otherwise subject to chapter  
16 521E.

17 Sec. 100. 1993 Iowa Acts, chapter 158, section 4, is amended  
18 to read as follows:

19 SEC. 4. EMERGENCY RULES. Pursuant to sections 1, and 2, ~~and~~  
20 ~~3~~ of this Act, the commissioner of insurance ~~or the director of~~  
21 ~~public health~~ shall adopt administrative rules under section  
22 17A.4, subsection 2, and section 17A.5, subsection 2, paragraph  
23 "b", to implement the provisions of this Act and the rules  
24 shall become effective immediately upon filing, unless a later  
25 effective date is specified in the rules. Any rules adopted in  
26 accordance with the provisions of this section shall also be  
27 published as notice of intended action as provided in section  
28 17A.4.

29 Sec. 101. REPEAL. Section 135.120, Code 2017, is repealed.

30 Sec. 102. REPEAL. 1993 Iowa Acts, chapter 158, section 3,  
31 is repealed.

32 Sec. 103. CODE EDITOR'S DIRECTIVE. The Code editor shall  
33 correct and eliminate any references to the term "organized  
34 delivery system" or other forms of the term anywhere else in  
35 the Iowa Code or Iowa Code Supplement, in any bills awaiting

1 codification, in this Act, and in any bills enacted by the  
2 Eighty-seventh General Assembly, 2017 Regular Session, or any  
3 extraordinary session.

4 DIVISION VIII

5 HEALTH DATA

6 Sec. 104. Section 135.166, Code 2017, is amended to read as  
7 follows:

8 **135.166 Health care data — collection and use — collection**  
9 **from hospitals.**

10 1. a. The department of public health shall enter into  
11 a memorandum of understanding to utilize the Iowa hospital  
12 association to act as the department's intermediary in  
13 collecting, maintaining, and disseminating hospital inpatient,  
14 outpatient, and ambulatory ~~information~~ data, as initially  
15 authorized in 1996 Iowa Acts, ch. 1212, §5, subsection 1,  
16 paragraph "a", subparagraph (4), and 641 IAC 177.3.

17 2. b. The memorandum of understanding shall include but  
18 is not limited to provisions that address the duties of the  
19 department and the Iowa hospital association regarding the  
20 collection, reporting, disclosure, storage, and confidentiality  
21 of the data.

22 2. Unless otherwise authorized or required by state or  
23 federal law, data collected under this section shall not  
24 include the social security number of the individual subject  
25 of the data.